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PSYCHOPATHOLOGY OF WORK*

By C. P. OBERNDORF, M.D.†

The antonym of work is play and we may best understand the normal physiological and psychological manifestations of work by comparing it with the spontaneous action characteristic of play from which it emerges. For play is instinctive and develops along with and out of autoerotic energy expenditure, beginning with the simplest autoerotic discharges at the pregenital level, such as a baby playing with its toes. Long before definite genitality has been established, play may begin to include an expression of early instinct components, such as exhibitionism, sadism, scoptophilia, etc. The pleasure in simple forms of play lies then in the gratification through the occupation itself, and when occupation and achievement are one and the same. Thus it is a common practice in the teaching of young children to attempt to make a game of simple tasks so that the achievement pleasure is incidental and unperceived by them. This is frequently readopted, reappropriated by the children themselves in such games as playing school or keeping house, or rehearsal in the form of play for some impending task.

Quite early, too, in the child's development, play begins to incorporate a degree of learning and eventually the amount of learning involved may become so great that in some games it is questionable where play ends and work begins. For example, in American football, a game which allows abundantly for the intense gratification of primary instincts and instinct derivatives, especially aggression, the rules are so complex and application to execution so exacting, that it often assumes the aspect of work in the long, arduous hours spent in practice before the final exhibition against the extrafamilial rival. At the same time the rules, through the imposition of penalties for such primitive breaches as unnecessary roughness or clipping, become internalized by the players and serve as a super-ego defense against too complete a regression to unrestrained brutality.

* Presented at a staff forum of the Menninger Foundation, Topeka, Kansas, September 7, 1950.

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Work normally is associated with some affect of discomfort or deprivation not associated with the pleasure of spontaneous play. Perhaps the essential difference between the situations which play and work afford lies in the fact that the pleasure, comfort, satisfaction derived from play is immediate and that from work is usually deferred. This time factor often becomes important and is manifested in rapid, slip-shod performance or procrastination. The discomfort or denial which is normally associated with work is borne by the individual in the hope that he may eventually be rewarded with something pleasurable in the form of body sustenance, or some libidinally invested acquisition such as clothing, articles for adornment, or recreation, or some definitely sexual object.

The close inclusion of many, perhaps all of the libidinal drives in work seems so obvious that the thesis that work is devoted to self-preservation alone does not seem tenable. Freud early pointed out that in the mechanism of sublimation the primary sexual aim becomes desexualized, at least to a very considerable degree, but the same pleasurable impulse finds expression in some socially acceptable occupation or vocation. Some analysts are inclined to restrict the term *sublimation* to pregenital sexually invested activities and maintain that fixations at some pregenital pleasure level determine the choice of occupation—especially in the professional field, through a direct expression of overcompensation. In sublimation, the unconscious incestuous fantasies are partially absorbed and thereby divested of their guilt.

Hendrick* maintains that the work principle is "the need of human beings for the pleasure afforded by the effective integration of neuromuscular and intellectual functions, and although generally experienced together with libidinal pleasure, work pleasure is not primarily displaced or sublimated sensual pleasure." This concept would make work a function of the ego, the psychology of which has recently received increased attention. The validity of his position depends on the scope of the word sensual, whether this be restricted to pleasurable body sensations as such, or to a generalized feeling of physical well-being which often accompanies or follows achievement.

Whatever value may be ascribed to this achievement aspect, in the consideration of the psychopathological aspects of work habits, we must estimate to what extent libido from primary autoerotic sources is involved where the investment of energy is too little (laziness), or too slight (indifference), or too great, too long and too much (over-industry). Such imbalances in application to work may occur in any occupation or profession or vocation. As one patient put it neatly "Work takes you away from home

* Hendrick, Ives: Work and the Pleasure Principle. *Psychoanalytic Quarterly* 12: 347, 1943.

and home is the place where one should give love—I guess that's the reason why I always somehow contrive to have three deals on the fire in my office at once."

Quantitative measurement of the amount of work which is to be considered desirable or proper is flexible, dependent upon the current standards of the environment. Even more than the community estimates of normality and propriety in this direction are those established and inculcated in early life by parents or their immediate surrogates and slowly absorbed (introjected) by the developing child as guides and ideals for application. The need to fulfill or reject these ideals is then determined by the original libidinal relationship of the child to the parents and leads to an overdevotion to duty in work, such as a compulsion to finish at one sitting a job which has been undertaken, or a refusal to apply oneself to work which one is perfectly competent of accomplishing, such as not studying or not thinking or even not being able to think (thought block). In the latter instances the individual involuntarily (unconsciously) denies to his parent imago the pleasure of satisfaction but may not escape the feeling of guilt. Indeed one of the frequent punishments throughout life for transgressions of prescribed conduct is the assignment of work, whether this be staying after school and writing fifty lines at teacher's command, or serving fifty months in the workhouse on sentence by a judge.

In clinical practice the psychoanalyst finds that the interdependence of the distribution of libido and work is the most important factor in the adaptation of the patient to demands both within and outside marriage. The element of duty, regard for the demands of conscience, enters both consciously and unconsciously into most of our undertakings. The feeling of obligation accompanying work, which is almost never present in playing, may be a residual of the need to conform to the regulation of early sexually tinged activities. Thus defecation, often euphemistically referred to by parents of the child as "doing his duty," may continue in a pathological urge to work, to produce something worthwhile, or as a refusal to apply himself to work and just make a mess, or sit tight. In the household of one patient now under analysis, the phrase for inquiry as to bowel movement is, "Did you read a book this morning?"—the bathroom is called the library of his father—or, in another case, the mother would ask, "Were you busy this morning?" "Yes, mother." "Busy, busy, dear?" "Yes, mother" (the "busy, busy" in this case meaning a full movement).

The avoidance of work was a pronounced and extremely crippling symptom in a patient, aged forty-four, on the borderline of schizophrenia, who had been under analysis for fifteen years when analyst and patient began to disagree. He had been unable to mobilize consistently his high quantum of libido from autoerotic indulgences—especially overeating, long hours

of sleeping and persistent masturbation—to constructive or allogeneous activities and for nearly twenty-five years (from the age of twenty to forty-five) had done practically no work. With the sharp insight into the unconscious which schizophrenics sometimes display, one day he burst forth, "I don't work. I try forever to avoid getting away from the breast. My whole life is treading water so as not to progress, staying in the same state where I kicked around in the embryonic fluid." His choice of the words, "treading water," is really graphic and the whole picture one of clinging to autoerotic self-preservation.

At the genital level in adults the forepleasure in normal sexuality is often referred to as play, which is followed by getting to work where the aim (ejaculation) becomes more definite. One patient equated play with infantile sexuality and work with adult sexuality.

Also at the genital level analogous associations between the neglect of work and sexual energy distribution may occur more or less consciously. There may exist the idea that ejaculation is loss of energy, loss of energy means less power to work and therefore sexual relations should be indulged in sparingly if one is to accomplish one's tasks adequately. Excessive masturbation may be followed by a formula something like this—now you are too exhausted to work—if you don't work you won't succeed—and if you don't succeed you are a failure—and if you fail you will punish (disgrace) mother who does not allow you to gratify yourself with her. Likewise the conception of loss of effectiveness in work seems to be the unconscious basis of the pathological indifference to sex matters in many men who feel that occupational achievement should have ascendency over love. The husband of a patient now under analysis, a highly successful surgeon, will never have relations with her on the night before he is to operate and as he is on the staff of two large city hospitals he operates almost every day.

In back of the overemphasis on work for success rests the fear that one or the other parent of the person will not love him unless he succeeds. The need to retain such praise, or the hope, still late in life, that he may through diligent effort achieve that love of the parent continues and may surpass the love of the wife. A similar mechanism is found in women where the drive toward work (success) in civic affairs, usually dependent on identification with a beloved and powerful father, absorbs too great a quantum of libido to the detriment of her home and family.

I should like to refer at some length to a patient whom I first saw nearly twenty years ago when in his sophomore year at Princeton he was compelled to discontinue his course because of an inability to concentrate on his work. He lay in bed most of the day, indulged to an almost unbelievable amount in masturbation, refused to do the simplest tasks, and could have

been regarded as a case of schizophrenia. After long analytic treatment, during which his adaptation to work was always a major problem because of his spasmodic application and quarrels with his employers, he became a highly successful business man engaged in a field where shrewd and ruthless trading is legitimate. Indeed, as his maturation progressed, for a time he became interested in his work to a pathological degree. At that period his residual infantile strivings did not come to the surface as long as he expended most of his energy in work.

The patient's mother was the dominant, powerful, ambitious force in the household and all of her inexhaustible, masculine drive, which had no outlet in her ineffectual husband, she concentrated on directing the patient's efforts in tennis and in scholarship. The patient had been a student of unusual brilliance and promise in high school but when deprived of his mother's direction while away from home at college, he became confused, apathetic and disinterested—an unconscious reaction formation of defiance to her. Indeed his failure devastated her, for her displaced life ambition had been shattered. One can well understand the obstacles which such a person might put in the way of a therapist because she felt no one else should succeed with her son if she could not.

Perhaps the portrayal of the patient's difficulties with work which were closely involved with those of time can be illuminated by a quotation from his own description written about five years ago. "I never could do anything which had no importance. I never could joke or really have fun. There was always a continual pressure on me and to a somewhat lesser extent this is still the case. It is all right to have an ambition or goal. My mistake is constantly thinking of what I want to do in the future. Still too many of my present acts are tinged with a purposeful future. Going ahead fast the way I have been the last year makes me want to go ahead all the faster, but I may knock myself out by this, particularly if I can't relax.

"My not being able to finish things is somewhat due to the fact that *actually* starting anything takes so much conscious energy and so much *holding down* of unconscious habits that would ruin the start, that I have little energy left to think about the finish. Usually when I think about finishes, *I am not acting in the present.* I am trying to keep my changes gradual as this does make for such a strange feeling of unreality. Sometimes I get used to doing a thing consciously but after I don't do it for a while, if I try again, unconscious feelings which I sense pop up and make it very difficult.

"My mother discouraged semi-routine things or a partial using of the mind on anything until it became a habit with me, like brushing the teeth. Thus on certain tasks where my mind should have been going at half-speed,

I either didn't use it at all or I used it too much. I still plan for the future too much and act in the present too little. I am trying to get the present where there actually will be a little leeway of action."

It will be perceived that with this patient the ego ideal (super-ego), namely work, work, work, had assumed a dominant feminine tinge which made it incompatible with masculine strivings. When the patient's insight and realignment of his values improved, it became evident that a moderate, average day's work did not reduce him to helplessness, in his psychology the feminine position. This excessive reaction to work happened only when he was overcome by the need to be superlative—to make bigger, more spectacular transactions. This urge manifested itself not only in realistic undertakings but in fantasies so vivid and incongruous ("crazy"—to use his expression) that they became disturbing. For instance, at a political meeting in a hall, profuse fantasies would swamp his mind, such as that the chairman would call out that he was wanted on the telephone. Then he would fantasy that he would leave the room, return, mount the platform, announce that the call had been from President Roosevelt and the President had directed him personally to address the gathering. The fantasy was followed by collapse, which made him feel like a baby, and he would refer to himself by some deprecatory anal or urinary epithet.

The patient's drive to be important, powerful, masculine—far too exaggerated—was bound to react in disappointment, defeat, impotence. When this occurred he felt as if he had been "knocked out" physically and made helpless like a woman. In a less severe form the same symptom was noted in his daily work. If some particularly important affair occupied his attention, at about ten or twelve in the morning he began to feel tired. This would last until he came home and then he would feel weak and be sexually impotent.

Perhaps we may generalize from this specific instance that if success in work is too greatly invested with feeling value, in consonance with a super-ego ideal, there also exists an unconscious wish to lose or fail. Failure would permit the individual to regress to the infantile level where he might please the mother with less, that is with a purely playful effort. Whether or not this is the desire, it is unquestionably the result.

The patient had always indulged in masturbation fantasies of torturing women and felt compelled to continue them in intercourse before marriage and with his first and second wife, with whom he is now living happily, and by whom he has three children. But in his masturbation he had assumed an all powerful position which soon became untenable, for he could not continue for long at being so masterful and ended up a blubbering little boy. Such super-strength drives, when thwarted, cause the individual to fall back rapidly and at times tragically into helpless moods of depression.

When the patient's compulsion to work gradually weakened and he began to play golf he once remarked that golf is really a solitary game for there is no comeback from the ball such as one would receive if one approached any living thing with equal aggression. Golf reminded him of earlier days when he spent much time playing solitaire at cards and would alternate the game with frequent masturbation. In golf his primitive impulses to violence reappeared and he said that he actually felt temporarily "crazier" on the golf course than he had been during some phases of his serious mental illness. To him the only pleasure derived from golf consisted in the moment when he struck the ball and all his viciousness, bitter aggression and latent sadism found release. To him walking around the golf course represented only arduous work which he hated, but any form of play had to have an element of work for him if he were to indulge in it at all.

This same patient, who had been an expert bridge player, commented that unquestionably expert bridge required so much concentration that it really constituted work. When his libido during the course of the cure became invested almost exclusively in his work he found it impossible to muster sufficient energy at night to play good bridge. He now replaced his former expert bridge associates with second-rate players where, because a certain amount of banter was allowed during the game, it assumed more the aspect of play through the immediate release of affect.

Many terms borrowed from sport indicate that an unconsious association exists between organized play and sexuality. Taking lessons in golf or tennis turns play into work (pleasure deferred) and the idea is so distasteful to some persons that they cannot bring themselves to do so. The teaching of sports is an example where play is actually considered work by the instructor and the pupil as well. In the case of the professional player of baseball, tennis, or football, play usually becomes work because of the introduction of the wage element (self-preservation—food) and the more serious consequences of error, while the amateur engages in sport primarily for the regression of earlier physical enjoyment (muscle erotism, unrestrained aggression). The activity in the work of playing (the professional) is usually associated with closer supervision from without and entails more drastic submission to outside authority than to super-ego pressure.

Perhaps the practice of making bets in golf or bridge, even small ones, contributes an incentive of having something tangible for which to work; in other words, introducing into the game an aspect of reward or gain—divesting the recreation of some of its play element and transforming it into an approved (work) expenditure of time, thereby removing some of the sense of guilt in reverting to the play of earlier days.

A man who is tense at his work, through his very concentration holds in check any desire he might have to revert to childish activities, and this

suppression eventually becomes automatically a repression. Therefore, a person who no longer has a conflict about reverting to the emotional level of playful enjoyment, works more easily and at the same time may foster this tendency by allowing acts to appear which might be primarily of a childish nature—such as occasional kidding*—which in turn may make the accomplishment of his task smoother. In most offices because of this unconscious conflict, one or the other attitude toward work is apt to be the rule: either too much playfulness in the present or too much concentration on work so that it becomes drudgery. Perhaps in businesses where work is performed most successfully, allowance is made for the occasional emergence of (regression to) play.

Conclusion

Persons who constantly regard work as something difficult and unpleasant are those who have not emerged from the necessity of immediate reward and who are reluctant to assume responsibility (self-support) inherent in maturity. The protraction of infantile pleasure or the necessity for its denial as one matures determines the overinvestment or underinvestment of libido in work. This interrelationship is a close and continuous one and it seems futile to attempt to distinguish whether such libido is preponderantly sexual or ego.

* Oberndorf, C. P.: Kidding—A Form of Humor. *Internat. J. Psychoanalysis* 13: 479–480, July, 1932.

PSYCHIATRIC SOCIAL SERVICE IN A SMALL PRIVATE PSYCHIATRIC HOSPITAL*

By MARCIA A. LEADER, M.S.W.† and LEWIS L. ROBBINS, M.D.‡

Social work has a long history of service in public mental hospitals where it has been well-defined and its contribution to effective patient treatment accepted. For many reasons the practice of psychiatric social case work in the small private psychiatric hospital is a recent development. One reason for this late development is the social worker's historical identification with the economic needs of the under-privileged. One might ask: "How can a social worker help people who are able to pay for private psychiatric hospital care and who are economically adequate in other areas of their lives?"

Psychiatrists have lacked an accurate understanding of what the psychiatric social worker is professionally trained to do and what lies outside of the social worker's area of professional competence. Social workers themselves have not always been entirely clear about their professional purposes because of the rapid evolution of social work. Through the years and in different hospital settings social work has been variously defined as: gathering data about the patient's social environment for the psychiatrist's use in arriving at a diagnosis; performing a variety of duties which, if the doctor were not too busy, he would handle himself; directly inducing changes in the patient's social environment; gathering reports on the patient's social adjustment after discharge; and practicing psychotherapy with the psychiatrist.

In our hospital,§ the social worker has therapeutic responsibilities differentiated from those of the psychiatrist, but integrated into the total treatment program. The primary responsibility of the psychiatric social worker is to help patients and their families find solutions to the situational problems related to the patient's illness and preparation for return to community living. The psychiatrist's primary responsibility is to alter the course of the disease process and bring about changes in personality structure in the patient and to coordinate the hospital milieu program.

This differentiation is based on the specific training and experience of the psychiatrist and the social worker respectively. The doctor thinks first and last of his patient. The social case worker studies the family and

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community relationships of the patient and knows how to develop them to improve the patient's social adjustment. Inasmuch as the patient and his social reality are intimately related, *sustained* recovery often requires both psychiatric treatment for the patient and social case work help for the family as well as the patient.

This type of social work is essentially no different from that of the psychiatric social worker in the public psychiatric hospital. Patients with the same kinds of mental illnesses are admitted to private as well as public hospitals. The interpersonal and social problems that have contributed to the development of the patient's illness and that follow in its wake are basically the same for both private and public hospital patients, although because of social and economic factors they may be expressed differently.

There are, however, factors and problems unique and specific to the small private psychiatric hospital which affect the development of social work and the definition of the social worker's role in this setting.

One of the most significant differences between the private and public hospital is the economic status of the patients. The cost of private hospital psychiatric treatment limits the patient group. This does not mean that money is no problem to the private hospital patient or his family. Because of the usual duration of hospitalization for psychiatric illness, the expense of treatment may be a heavy burden to the family, sometimes even necessitating a reduction in its standard of living. People who have some means to pay for treatment often find it difficult to face the financial hardships and limitations that private hospitalization may impose. They may also find it difficult to accept the fact that a social worker, identified in the layman's mind as someone who aids the poor, works with them as part of the patient's treatment.

Another difference is that the private hospital patient and his family are free to terminate treatment at any time. The hospital in turn is free to decide whether or not it is desirable to go on treating the patient, depending on the way he is able to use the treatment resources. Therefore, the question of continuing hospitalization is always being weighed and balanced, both by the patient and his family, and by the hospital.

For many reasons, the patient and his family press for rapid results. In order to maintain an active treatment program, the hospital is always conscious of whether the patient is responding adequately to the treatment available. In the private hospital this pressure of decision is an ever-present reality with which the social worker must help the people involved.

In our small private hospital an effort is always made to write or see the patient's closest relative and arrange for him to accompany the patient to the hospital. In this way, the relative is shown that he has a part to

play in the treatment. A social worker is always present with the doctor when a patient is admitted, and interviews every relative who accompanies the patient. We believe that the success of the patient's treatment depends in part upon our immediate recognition of what the patient's illness means to the relatives and what the social worker can help them accomplish in their relationships with the patient.

The admission is an emotionally-charged time for the relative as well as for the patient. He is feeling the natural anxieties that accompany bringing a patient to a new, strange, and foreboding place and leaving him there. In addition, the relative may feel guilty about his part in the patient's illness and uncertain about the decision to hospitalize him. He may be hurt and bewildered by the patient's hostility towards him, and ashamed of his own hostile retaliation. His motives in hospitalizing the patient may be unclear. At times the relationship between patient and family may be so deteriorated that the relative in his discomfort seizes upon hospitalization as a way of deserting the patient. He may be confused by misconceptions about mental illness and fearful of the implications that someone close to him is ill in this way. He may be determined to make a last-ditch stand against accepting the fact that the patient is mentally ill. He may not know whether he should tell the people back home the truth concerning the patient's condition and whereabouts. He may be so bound up by anguish that he cannot bear to part from the patient and entrust his care to strangers. He may be wondering what he will do if the patient refuses to enter the hospital.

We are familiar with the part that the significant people in the patient's life have played in the development of his illness. It is impossible to begin to refocus the patterns of these complex and distorted relationships by simple authoritative edicts, by firm instructions, or by intimidation, any more than it is possible to treat the patient's illness successfully by similar approaches. We do not tell the family to go home, to trust us, not to worry, or not to bother us or the patient. Instead, the social worker helps the relative with the very real problems that the patient's illness and hospitalization create for him, so that he may be free to participate constructively in the patient's treatment. He is given an opportunity and encouraged to express his feelings, and to discuss his problems in the present situation so that he may arrive at his own decisions and take action on them, thus reducing some of his anxieties. The social worker also orients the relative to hospital procedures and the steps he must take—signing the applications for admission, discharge, permission for special therapeutic procedures, and assumption of financial responsibility. He discusses the family's financial situation, establishes fees that are set in accordance with income, and helps

the relative make some practical plan for meeting the cost of hospitalization. He explains the ways in which the relative can help the patient, and supplement the treatment.

The social worker then makes another appointment with the relative to discuss his views of the patient's life and the development of his illness, and if necessary, to work further on whatever problems remain to be resolved. Feelings and problems if left unexpressed and unresolved, may block the relative's working with the hospital, thus interfering with the patient's recovery.

In meetings of the clinical staff the social worker presents his findings about the family situation, his evaluation of the role the family has played in the development of the patient's illness, and his conclusions about the family problems and strengths, as they relate to the initial planning of the patient's treatment program.

The initial interviews with the relatives mark the beginning of a relationship between the relatives and the hospital, represented by the social worker, which continues throughout the course of the patient's hospitalization. This contact is maintained both by correspondence and by subsequent personal interviews which may be requested by the hospital or the relative. The social worker can help the family cope with the feeling of isolation from the patient which is apt to develop during his hospitalization. A patient's failure to respond to treatment, despite our every effort, poses new problems for the family. The patient may become openly hostile toward his family and sever all communication with them. As the patient gets well the family must progressively become acquainted anew with him. Sometimes a relative reacts stormily to the gratifying recovery of a patient, revealing an underlying wish that the patient remain ill. These are the kinds of problems that the social worker handles.

Continuous collaboration among all members of the clinical staff through regular meetings is essential to effective treatment of the patient and social work help for the relative. The social worker provides a dynamic picture of the family situation as it shifts and changes during the course of his work with the family, which the staff utilizes in treatment plans. The doctor presents to the group the trends in the patient's treatment and the situational problems as he becomes aware of them through his work with the patient. This information the social worker, in turn, utilizes in his contacts with the family.

The patient's doctor also maintains contact with the family through regular reports on the patient's progress and through meetings with the family at significant stages during the patient's treatment. In these contacts, the doctor gives his opinion about the patient's condition, an evaluation of his progress, and makes recommendations. While the doctor is interested

in the patient's family, his primary identification must be with the patient. It is neither effective nor economical for the doctor to attempt to maintain simultaneous relationships with both patient and family. When the *patient* has the doctor's undivided interest, and the *family* has the social worker's main attention, patient and family do not have to compete destructively with each other for the doctor's interest, understanding and help. As a result some patients have improved dramatically and fewer families have precipitously removed patients from the hospital.

We believe that the relative's continuous relationship with the hospital through the social worker is part of the patient's treatment. The social worker does not undertake the treatment of the relative's personality problems as such, though therapeutic results sometimes come as by-products of this relationship.

During the initial phase of hospitalization in which the patient is struggling with the problems of accepting his need for hospitalization and treatment, the psychiatric social worker does not have any continuously direct relationship with him. In our hospital it is the doctor who helps the patient with his feelings about hospitalization, and discusses his motivation for treatment, plans with the patient the over-all treatment program, and assists the patient in entering into this program. After conferring with the patient's doctor, the social worker sees patients who are concerned about problems related to home and family, settling business affairs or other specific reality problems, and helps the patient to work these out within the limits of the patient's capacity at any given time.

When the patient's discharge is approaching, he may be confronted with the problems of translating the gains he has made in treatment into concrete plans for his future. Before making the transition from the hospital to his original community, he may need a transitional proving ground. This is provided by a period of living and working in our local community and continued treatment as an outpatient. When ready for this step he is referred to the social worker. He is likely to have a number of reality problems such as finding employment, resuming schooling, making a social adjustment to community living, and securing the type of living arrangements best suited to his needs. The social worker helps the patient utilize all possible resources within the community to meet such problems and guides him in his planning. With those patients for whom family living is therapeutically indicated, the social worker locates a suitable foster home, helps the patient to enter into the foster home plan, and maintains continuous contact with both patient and foster family. Whatever the specific reality problem may be, the social worker provides help to the patient in a way designed to strengthen the healthy aspects of his personality and to consolidate the gains he has made in treatment.

As the patient becomes ready for discharge and return either to his own community or to our local community, the social worker considers the implications of this move to the relative. New problems often confront the family and old anxieties often return. After the medical recommendations are given, the social worker helps the family make plans to put these into effect and to resolve their feelings about the patient's next step.

Our experience thus far points clearly to a few essential facts on which a sound social service program in a small psychiatric hospital needs to be based. Treatment of the patient has limited value if the patient's closest relative is not helped to become an active participant in that treatment. Engaging the participation of a patient's relative thus becomes the most valuable contribution that the psychiatric social worker can make in the small private hospital. The social worker is the person to carry this responsibility because of his specialized training and skill in helping people meet problems in their social reality. Not only does such a service augment the total therapeutic effort, it also releases the doctor to work more intensively with the patient.

When, as the result of his therapeutic work with his doctor, the patient becomes ready to tackle the problems of living away from the protective and specialized hospital community, the social worker is the person to assist him with the various reality problems attending these forward steps. For the best integration of the kind of social service just described, collaboration between doctor and social worker is indispensable on the administrative as well as the practitioner level. In the two and a half years in which social workers have been active members of our hospital staff, carrying a specialized and essential therapeutic responsibility, they have contributed greatly to our ultimate treatment objective: The return of the patient to effective community living.

Introducing a social service program in a private hospital inevitably means re-defining the responsibilities of other staff members. In attempting to provide a more effective treatment program, interprofessional problems will be created. Many areas of overlapping exist. What provisions need to be made to prevent the destructive competitiveness which ultimately harms the patient? To what degree does the hospital give psychiatric social work the responsibility for defining its own role, and how willing is psychiatric social work to take this responsibility? Upon the resolution of these and related problems rests the future of social service in small private psychiatric hospitals.

AN APPLICATION OF THE THEORY OF PSYCHOSEXUAL DEVELOPMENT TO THE LEARNING PROCESS*

By R. L. SUTHERLAND, M.D.†

One of the basic theories of dynamic psychiatry concerns the several stages of infantile psychosexual development. There have been several classifications following Freud's original description of the four main stages[1]: the oral, the anal, the phallic and the genital. There have been some fairly well accepted subdivisions into active and passive oral and anal phases, and a rather indefinitely defined urethral phase.

Erickson[2] has illuminated the discussion of the developmental stages by proposing a mode of action appropriate to each level of development, often carried out in other than the zone for which the developmental stage is named. Abraham,[3] Jones,[1] Menninger[5] and others have used similar approaches in discussion of oral and anal tendencies. For instance, active orality may express itself in a biting use of the mouth, in a grasping attitude toward life generally, in incisive thinking, or in a number of mannerisms expressing the impulse to seize. The anal expulsive mode may show itself in the mouth by spitting, or by an explosive, profane or obscene type of speech, or in the muscular system by striking out after a period of pent up control. The male phallic mode of extrusion may be seen in all types of thrusting behavior with limbs or tongue, or by peering and penetrating with the eyes or the understanding.

Some recent experiences with the learning process have led me to the hypothesis that a person approaches the learning and the mastery of any new situation by stages strikingly similar to those of infantile sexual development. In some ways, this hypothesis is an extension of Erickson's description. It regards the functional characteristics of the stages of development as having greater significance than the anatomical. It considers the mode, the form of behavior, during a certain period of life as being characteristic, rather than the body zone from which such behavior seems to arise.

Thus, we might think of the passive oral stage as one in which adaptation is largely internal, and in which no effort is made to get supplies from the environment except by the act of communicating the needs to all-supplying

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agents, particularly the mother. The cry for food or warmth or support, and the tissue adjustments to absence or presence of supplies, constitute passive oral adaptation.

In the stage of active orality, with the development of teeth and more vigorous muscular control, there is a tendency to grasp the source of supply; to seize and to incorporate the breast; to hold on to what is given, and to assert a general effort at domination over its origin. Not only a further plea for help but also an aggressive, selective attack on the source of supply typifies this stage.

In the anal stage of development, relationship with other people emphasizes the question of mastery. The child struggles for the means of control of his own body and the right to control and to use it. The sphincters and the skeleto-motor system are chiefly involved. This is the stage of increasing coordination; and the struggle for independence follows upon the mastery of each motor pattern. The typical cry is, "I want to do it my way," expressed in all of the activities of the day. It is as though the body had been given the child during the oral stage and he struggles now to assert his ownership of it.

In the phallic stage, ambition to be noticed, to excel, to be admired in the use of the newly won body is the theme. This is the stage of competition. The child fears the body or its functions will be taken away. There is a testing of the limits between the self and others. It is not now a struggle for independence, but one for domination and influence. It is not now a demand to be let alone to do the job in one's own way, but the demand to be held in esteem above others. The magnificent erect penis has the magic to fascinate, to stimulate, to ignite, to cure. With the girl, her skin, her hair, her movements are the charms that awaken the sleeper, that bring the penis to life. And against the urge to fascinate and to overpower, is always the danger that if one goes too far, his magic or her charm will be taken away. The threat of castration is the reverse of the coin; it limits the phallic striving.

According to theory, when genital maturity is reached, the satisfaction of the body springs directly from use. There is no fear of starvation and abandonment, since the sources of supply are established and controlled. There is no struggle for the independent use of the body, for the body parts have been coordinated, the functions have been learned and control over them is more or less complete. The fear of castration is minimal, for the power to love and to be loved, to stimulate and to compete has been fully tested. The limits beyond which one cannot safely go have been discovered. The territory of one's life activities has been fairly well staked out. Now, within this territory, the life energy can be turned to enjoying

the functions of body and mind that were so long in the winning and the establishment.

As we pass from the sketch of one developmental stage to the next more advanced one, we note a more and more schematic outline, in contrast to life as it is likely to be lived in any chronological period. We are increasingly aware that no stage exists in pure culture, and that mixtures of behavior appropriate to the latest stage and of all those preceding it are bound to occur. In fact, the idea of a genital person seems as unacceptable as a protein or carbohydrate person. How can the sources of supply be guaranteed, or the limits of competition be safely defined, or confidence of one's ability to love be assured in the face of contrary evidence from a world of people preoccupied with their own problems of supply, independence and ambition?

Not only each era but each new problem brings a change in adaptation. It is the observation of some of the typical modes of adaptation and their changes that constitutes the theme of this paper.

The observations came primarily from work with psychiatric residents, residents in internal medicine as they were exposed to a psychosomatic point of view, and with psychoanalytic candidates.

When a young physician enters a residency in psychiatry, he finds himself surrounded by teachers and books. He is flooded with information. He is oriented, indoctrinated, pointed along the path to higher goals and confronted with a variety of people to emulate.

His attitude at this point is generally one of acceptance and expectation. Especially if psychiatry is a new experience to him, he is confronted by ever fresh stimuli. His energy is directed toward absorption and orientation. He learns a vocabulary; he begins to see the individual patient in ways different from the past; new gestalten and broader concepts emphasize the passive aspect of his situation. He is aware more of what is happening to him than of his reactions in adapting to the change. His reactions are quite similar to the digestive, assimilative efforts of the newborn child. At this stage, the teachers are sources of supply, determining in their own fashion the way the supply will reach the student. He need only be reasonably attentive. As long as his psychic digestive system is intact, the work of making the new knowledge part of his body goes on automatically, without much awareness of how it is proceeding.

In a few weeks or months, however, the teaching staff becomes aware of a change in the resident. He takes a more active part in the learning process. His questions become less general. Whereas at first his questions may have been few and of the general form, "What do you mean when you say so and so?" now he asks more specifically and pointedly, "If A and B

are so, how does C follow?" "If a permissive attitude helps a patient, why does he get worse when rules are not enforced?" "What are the connections between what we heard last month about treating depressions with menial tasks and what we see now of electric shock?"

The greater degree of participation is considered a sign of progress by the teacher, who will usually encourage a more meaningful asking of questions. However, in the late oral stage, when biting and grasping are increasing, the child's behavior might be characterized by the protest, "It isn't enough." Similarly, the student, as he begins to be more active in the intake process, starts in a more or less overt way to criticize his teachers. He finds them repetitious, insufficiently clear, indifferent to his special needs, failing to give him certain courses he expected or including too many other students in a group. At this stage of infantile development, the good parent begins to wean the child. Less is given him from the breast, and more is put within his reach to take or not as his appetite directs. But in the case of the adult student, his teachers often feel that protest and increased demand are signs of rebellion that must be quelled; or that the demand, being justified in fact, must somehow be met by a greater supply. In either case, such a response from the teacher is contrary to maximum development. It might be argued from analogy and can be supported in experience, that a better teaching method is to allow the student to voice his protest, to show him that his demands are understood and accepted, and to permit him to find the answers to his needs in the library and in a staff ready to answer his questions, but not eager to continue the gratuitous pouring forth of information.

The next stage of development, according to analogy, would be an equivalent of the anal stage. Not to draw too fine a line by dividing this stage into expulsive and retentive phases, we might look for a working out of the problem of independence and of ownership. This we see in the psychiatric resident when he begins to formulate ideas in his own way, to defy with various degrees of subtlety any implied demand that he return information to his teachers in a prescribed form. Inasmuch as we are dealing with responsible physicians, we can expect defiance to assume forms compatible with the adequate care of patients and a conventional show of respect for authority. But if we look for it, we can observe the resident reacting to what he deems a demand by slavish attention to detail, scrupulous cleanliness and accuracy of work, copious reporting, indecision about particulars and all the other manifestations of fixations at the anal-compulsive level of development. These signs are usually of less than clinical degree but may reach marked intensity. Occasionally more overt forms of aggressive defiance show themselves in refusal to work at certain tasks,

in coming late to conferences and in leaving early, in postures and gestures of contempt and in the perfunctory fulfilling of basic requirements.

These latter reactions are frustrating to the teacher. The staff traditionally reacts by clamping down. "These doctors are not children. They have to shoulder responsibility . . . or else." Students are usually faced with the choice of producing or getting out, with the third possibility, in a psychiatric setting, of seeking treatment, occasionally as a token of their good faith. The response in the great majority of residents is a concealment of resentment and defiance beneath the mask of evasion and the subtler sarcasm of excessive obedience. In general, the overt struggle becomes a covert one. The defiant pupil becomes the obsessive one. Order has been established. But the fact that all these reactions are in response to what the student experiences as an unwarranted demand has not been explored

One might well argue that any demand will seem unwarranted to such a student. My thesis is that "such a student" is any student, and that the stage I am describing is an inevitable struggle for ownership and control of what has been given him. Therefore, the demand to which he is sensitized at this time is any effort by his teachers to maintain control over the way he expresses and coordinates his new knowledge.

The question of conformity is that of bowel training and, I propose, of any training after the question of supply has been met. The standardization of work so necessary to the efficient operation of a clinic, a hospital or any group enterprise demands conformity. But such a requirement appears to reactivate the suspicion of the child that he is being forced to conform in order to satisfy his parents' sense of power. The student's struggle to master the subject matter is perhaps in part projected onto the teacher, who is then assumed to enjoy mastery over the rebelling student. And if the demands and challenges of the later intaking (oral) period have been met by withdrawal and autocracy on the part of the faculty, such a suspicion will be in some measure justified.

The adult student who has mastered so many previous learning processes will be able to see the requirements of the situation in which he works. If the need for conformity is a real one and if his supervisor or teacher is not, in truth, reacting autocratically to the student's inevitable effort to assert mastery over his own skill, the student will usually enter the next phase of development.

In the urethral-phallic stage of psychosexual development, the material given, and now the child's own, is tested against the competing world. The question is no longer, "Can I use my body according to my own needs?" but "Can I use it to get admiration and love, to show it off, to supersede others with it?" The adult student now begins to assert himself in a way

different from that of the previous months or years. He goes beyond the requirements of his job. Ingenuity and imagination begin to show themselves. He probes and looks. He is interested in deviant theories or in the use of unusual treatment methods. He writes papers and takes an active part in group discussions. He exhibits his intellectual powers in new ways of looking at old subjects, in creative activity in his administrative and therapeutic tasks. He may defy or mock his teachers.

On the other hand, he may show in his learning and his work certain tendencies similar to symptoms found in the phallic stage. He may become more diffident about self-assertion. He may become more aware of criticism and may complain about colleagues who are competitive. He may energetically defend the established rules and show his competitive colors by outdoing his fellows in his knowledge of the literature. This period is one of heightened tension within the group of students, who are competing among themselves and yet trying to join with one another to overpower the authorities whenever they feel themselves opposed in their growing self-assertion.

Such a phase has its difficulties for the teacher. He senses the challenge to his authority in a third form. At first, he was accused of not giving enough supplies of the right kind; then his right to demand conformity was attacked; now his province as the knower and the proprietor of knowledge is in question. One of the main motives of the teacher may be to assert his own authority and to be the giver of the law. Insofar as this motive prevails, he will be particularly sensitive to any challenge to his status. His apparent motive to foster the maturity and independence of his students is given the lie. It is a question whether any teacher can remain comfortable when his proteges begin to challenge his most cherished beliefs. He is the father who, so soon, must make way for his sons.

Just as the greater demand for supplies must be met by an understanding sort of weaning, if growth is to go on, so must the challenge of authority be met by a freeing from the obligation to obey. In adolescence, the son and daughter must in time be given the right to decide for themselves how far they can go into life's perils; and obedience to parental judgment must give way to the reality testing of the child. Similarly, when the student's broadening and more forceful challenge of authority indicates a thrust toward independent professional status, the time has come for the teacher no longer to protect himself by his position as arbiter of grades and promotions. If he is to be true to his obligation as a promoter of growth, he must be ready to accept his growing challenger on equal terms in the arena.

It is this stage of the teaching process which tests the validity of the school. Just as the final test of the preparation for life comes in post-adoles-

cent living, so the last test of teaching comes with the ability of the student to compete in the open forum of his profession.

If independence can be gained without too much indirection, if the struggle with the teacher is fair, without insistence that certain holds be barred or certain areas not be explored frankly, the stage of exhibition and competition can be the most productive of the student's career. If not, if the castration fear, the dread of losing what he has gained through his own struggle, be too great, then the student falls back into the indirect method of reaction I have described. And in an excessive surrender to authority, in giving up originality and creativeness, he becomes, frequently, a much more acceptable student. The teacher glories in what is, after all, a forced or purchased admiration. And the alumnus becomes a good advertisement. At least in his overt utterances, he is a good representative. But, as with most false values, a man converted against his will is apt to let slip many deadly criticisms in his seeming effort to favor the cause.

After the struggle for an independent and creative scope, after the effort to test the limits of assertive activity, comes a phase analogous to the genital phase of psychosexual development. The student finds enjoyment in the application of what he has learned. The gratification of learning more, of mastering more, of exhibiting more are, of course, always present. But when the program has been finished, he finds himself thinking in order to solve problems, in order to create and to achieve. He is less likely than in the previous stage to challenge statements with which he disagrees, unless the issue is an important one. He is less concerned about the impression he makes and how his performance is accepted by his teachers, and more concerned with the pleasure of organizing his thoughts and his work.

In fact, he is really no longer a student but, in the true sense, a colleague of his teachers. He may be an assertive competitor or a highly cooperative co-worker. He may be one of these in one situation and another elsewhere. But he has learned the subject matter for himself and will continue to integrate it into his life pattern according to his many needs.

I have described what seems to be a parallel development between the learning process and infantile psychosexual development. What I have described in the learning process has been illustrated partly in a general way from recent experience with a school of psychiatry. But the same *motif* can be seen in any classroom or in the teaching of any new skill. At first there is the passive acceptance of information and orientation, followed by a more active approach to the source of supply. Then there is a more or less obvious struggle of compliance and conformity versus an independent use of the new skill, and an effort to establish ownership over

what has been gained. The following stage is that of the ambition to use and to show the new-gained strength and magnificence. Only after passing through these several stages of mastery, each with its own type of challenge to the teacher, and after avoiding a corresponding kind of defeat from the reactions of the teacher, does the student reach the stage of satisfaction in the skill or knowledge of and for itself, and as part of the job of living.

What are some of the implications of such a hypothesis? For one, it may be found that every individual living a complex life is at any one time in several stages of different learning processes. Every interpersonal relationship is a learning process; and the simple zest of a new friendship will be soon followed by a mutual maneuvering to gain supplies, a later struggle to assert control over the obligations springing from the relationship, a contest for admiration and prestige, both from the partner and in competition with the partner before other people, and finally, if these stages are successfully passed, a secure satisfaction in the relationship.

But again, how many relationships founder in the earlier stages, or remain fixed in a contest which remains undecided, at one or another level?

May it not be the reaction of the teacher which results in inadequate training, in the abandoning of a certain learning process in the midst of one of the early struggles? If the teacher refuses the student the right to make demands upon him for more and more supplies, or if he gives in unrealistically to demands and tries to continue the feeding process after the struggle for independence has begun, his student will find himself losing interest in the subject matter, turning to other fields or other schools of thought before he has had the chance really to test his new knowledge against his own needs.

The classical point of view in psychodynamics would perhaps suggest that any of the difficulties and struggles I have described is an indicator of some fixation or regression in the student, who, under the stress of learning, uses some self-determined method to cope with the difficulties, as he does in any situation.

There is no doubt that the teacher is seen by the student in accordance with his own needs and that he will tend to project his own conflicts about authority on to the teacher. It is my impression, however, that these projections and false perceptions of reality, if not too severe in degree, can usually be corrected by the teacher, if he recognizes them in time. I do not mean that the character structure of the student or his sensitivity to future experiences will be materially changed, but only that his neurotic rebellion, passivity, and negativism may be circumvented or rendered inoperative in a specific learning situation. I have seen this done in several instances by allowing students greater freedom in methods of work and especially by encouraging them to express their feelings frankly.

Discussion

A parallel has been drawn between the classical stages of psychosexual development and stages seen in any process of learning. But it seems unlikely that mere analogy affords an adequate insight. I suggest that psychosexual development itself is a learning process and that the stages described here comprise the more general formula. The phases of infantile development may be thought of as steps in the most important learning task undertaken by an individual.

Is there perhaps something inevitable in the sequence as Freud originally described it and as it is more generally applied here? Is it possible that an organism confronts its environment first on the basis of supply? The supply may consist of any sort of intake: food, sensory stimuli, radiant energy or other forms of influence. From the outset, there must be an adequate defense against unwelcome influences. Just as the suckling infant develops vomiting or pylorospasm or colic, so threatening experiences are avoided in the first period. Nourishing, growth-producing supply is welcomed; destructive supply is rejected.

Once the selection has been made between what seems good and what seems bad, can there be any development except as an effort to control the source of the good? And after some sort of guarantee against failure of supply has been established, can an organism do otherwise than to try to incorporate the supplies into its own design and use them as its nature dictates?

Beyond the point of establishing ownership and proprietorship of the substance and energy of the body, it seems fundamental to life processes that they keep striving for greater scope, and using all the available energy. This, in the development of the infant or of the student, corresponds to the phallic stage of growth. Ownership is followed by a testing of the limits of use. The phase of established, secure and satisfying use of the body or of the new skill can come only afterwards.

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THE INFLUENCE OF AN INTENSE TRANSFERENCE ON A SCHIZOPHRENIC PATIENT*

By ARON J. ARNOW, M.D.†

Wards for the mentally ill of our state hospitals, regarded by many as liable to discourage young psychiatrists because of the inertia of the patients and the hopelessness of the "chronic cases," actually present a wealth of psychopathologic phenomena. The bizarre and obscure behavior of some of these patients is not intelligible to the doctor at first, but if he visits them regularly with the attitude that their productions are a means of veiled communication, capable of being deciphered, he will be intrigued and rewarded beyond his expectations.

First, he will find that few of these patients fail to respond to an effort to understand them. Most of them are still capable of response to a therapist and many of them can develop an attachment to the therapist of fairly intense degree. With this link of understanding the therapist has a tool with which to help the patient make a better adjustment to the hospital and to show him how to increase his own comfort and to better his condition.

Second, the doctor himself has the opportunity to prove to himself that symptoms and psychotic productions can be understood and that the dynamic theories of psychiatry are illustrated in the most deluded patient. He has the unparalleled experience of seeing how the illness serves the patient's fears and needs. It is a vivid learning process for the physician.

This understanding cannot be realized, however, unless the physician is able to take sufficient interest in the patient and to give sufficient time to him to evolve an interpersonal relationship of some degree.

These observations, well-known as they are to experienced psychiatrists, make a great impact on the young physician when he makes them for himself in the course of his service on a so-called "chronic ward" in a large state hospital. It was such an experience which led me to report this case of a 38 year old schizophrenic woman who had been in Topeka State Hospital for six years. Her colorful productions and behavior illustrated to me vividly: (1) the mechanism of "bribing" the superego; (2) the schizophrenic struggle with homosexuality; (3) the belief in oral impregnation; (4) and above all, the phenomenon of transference and its role in psychotherapy.

Case Report

The patient, whom I shall call Mrs. A., had remained essentially the same during her six years in the hospital, and I should hasten to add, made

* Case Report from the Topeka State Hospital.

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no spectacular change during the nine months that I was in charge of her treatment. This is not a story of a "cure." It is rather the account of a fresh impact upon a student of the sensitivity and durability of the human spirit and the capacity for response that lives on among the forgotten patients in the dreary back wards of our huge state hospitals.

Mrs. A. slept in a women's ward, but during the day she appropriated the room of another patient and used it as if it were her office, resenting the occasional intrusion of its real occupant. She was entirely withdrawn from other persons and from hospital activities and refused, first passively and then with violence to leave her room or to share in any chore, exercise or recreation. Her sole occupation was reading a ragged New Testament and a stack of moving picture magazines. She never entered into a conversation or showed a desire for companions.

The history of the patient indicated an illness of long standing. As a child she had felt that her mother treated her like an outcast. She was described as a sensitive, obstinate and despondent girl who had her first "nervous breakdown" (crying spells and depression) at the age of 18, and her second (a confused state) at 28, after a year of unhappy marriage. Four years later, her father, who was her chief object of affection, died and the patient accused her mother of having poisoned him. Soon after this she expressed delusions of being poisoned herself and began to behave in such a bizarre manner that she was admitted to the state hospital.

There she wished to stay in bed and be waited on. When she was compelled to get up, she had to be strapped in a chair to keep her from lying down constantly. She would not do anything and was often restless and assaultive. At all times, except during a course of 21 electric shock treatments in 1945 when she showed temporary improvement, she refused to cooperate with anyone around her.

Lobotomy was considered by the staff for this patient and it was suggested in March, 1950 that I try to conduct some trial interviews with her to appraise her status before a decision about lobotomy was made.

I found her in "her room," a bare cell without a chair, sitting on the edge of the bed with her papers and magazines scattered about. She was dressed, as always, in a skirt and an exceedingly bedraggled and ragged sweater to which she ascribed magical protective and restraining power. "It keeps me from blowing my top," she told me later.

I began by sitting beside her and listening sympathetically to her. She soon talked freely about the people who were trying to influence her and told me of her imaginary protector "General Mills." She soon extended this protection to me, saying, "Whoever has an influence on me protects you also. You are supposed to go with me to California."

Within a few weeks, she began to dress nicely before our sessions, discarding the sweater. She admonished me: "Never touch any woman on

the ward except professionally." She often told me how her husband raped her and added that her policy was not to resist because of her fear of being injured.

"I know a secret which could put you under my *thumb* if I wanted to," she said, and showed me an advertisement of a "chirologist"—a hand divided by lines in different areas, that of the *thumb* named LOVE. Later she pointed with a meaningful gesture to another advertisement and said, "This girdle is you."

She continued: "They gave you to me. I will have a baby from you." "How can you?" I asked. "Through adultery. It is permitted. Remember the seventh commandment?" She wrote on the margin of the magazine: "Thou shout not; commit adultery."

As the patient had previously refused to go outdoors, I tried to give her an opportunity to enjoy the sunshine and fresh air during our psychotherapeutic sessions. I took her for walks and tried to divert her attention from her preoccupations and direct the topic of our conversation to actual reality. I was often successful and for a great part of the session we would talk about nature, journeys, and the hospital. We often went to a newsstand where she would select her own magazines. Her attention, however, could not be kept away from her delusional material for very long, and she would say: "You told me my ideas won't be understood by other people. I know that you don't want to talk about them either, but you have to. Whatever you think, this is reality to me."

I paid the price for her friendship and listened. She first mentioned her auditory hallucinations and explained: "I hear their messages after I know what they will say." Her persecutors, in the beginning a mysterious group of people who "put in money" to keep her in the hospital, crystallized in the form of an elderly woman, an ex-patient of this hospital. This woman, our patient complained, "gave away my pull to another patient, H. D., who was released from this hospital, whereas I sat strapped in a chair and was called names like 'trash.' She always wanted to have her way first and she will molest me until she regains her property."

I recognized in this account a reflection of her family situation when the patient allegedly was rejected and her sister was the favorite of her mother.

However, her delusions furnished her with a counterpart of "Daddy," and she had gained protectors in the form of "General Mills of Chicago." They had the secret of glamour and would release her from the hospital and procure her a position in the movie industry. With a fixed gaze she began to recite: "I am the King of Kings and the Lord of Lords. That is not the King of a country but only of General Mills. They are living gods. They have control on heaven and earth. They can influence the weather and make tornadoes. Remember the tornado in Oklahoma City? They did

it. I have power over them and give my commands by code. I have a powerful weapon and can do awful things. I prefer to overcome evil by good and forgive my trespassers. If shoved too much I will take revenge and they had better be careful and not lie about me. I can do more dirty tricks."

The latter threats were directed against the attendants who did not believe in her "Immaculate Conception." Like Mary, she was found with child from the "Holy Ghost" to whom she referred also as the "Hidden Man of the Heart" and the "Savior of the Body," and who was her "first love," the radio singer of her college years. The mechanism of this impregnation is described by the following Biblical passage which the patient read to me: "I took the little book out of the angel's hand and *ate it up* and it was in my mouth sweet as honey and as soon as I had eaten it, my belly was bitter." "Bitter means pregnancy," she added.

I was soon allowed by the patient to play a role in what was very much like an "oral impregnation mystery." Every day before leaving the ward, she took me to the automatic candy vendor and bought a "Baby Ruth" candy bar. She broke it in halves, took the one with the "Baby" and insisted that I eat the other half of the candy bar. She volunteered an explanation: "Baby means to come."

The oral impregnation phantasies were encountered frequently. She often complained of somebody putting powder in her food to make her *come*. "I come in my sleep," she added.

The patient had a positive attitude toward the male members of her family and was hostile toward all the female members. "My father was of sweet disposition and had high ideals," she said. "My brothers were always nice to me." In a letter to her mother the patient wrote, "They try to prove that I committed adultery. Am I going to be accused of what you did? They know it to be a fact." She also accused her grandmother of being for some time in a whore house.

Capitalizing on our relationship, I tried to interest the patient in adjunctive therapy activities. She resisted but finally gave in "to please" me. It was evident that it was a difficult concession. At first she tried to procrastinate and to return the material, because the "yarn was treated and my mind was blacked out." However, she surprised me with half a mitten one day and during the next few weeks she was very industrious and made three pairs of mittens.

In whatever concession the patient made, she was motivated only by her friendship for me. She was unshakably convinced that nothing but reading the Bible and magazines was worth her while. She was upheld in her belief by the authority of the Bible. "For bodily exercise profiteth little" (1 Tim. 4:8). She said: "I never participated in walking in a circle or working in the kitchen and instead spent my time in studying and

correspondence which is the right mental attitude because 'Godliness is profitable unto all things.'"

My attempts to make her sociable were rejected by her with a quotation from the Bible: "I have written unto you . . . not to company with fornicators" (1 Cor. 5:11). The women on the ward were fornicators, she said, "and if they are not—their relatives are." She refused to go to the dining room and backed her refusal with another quotation: "With such a one not to eat" (*ibid.*). She gave another reason for not going to the dining room: "When I go to the dining room, my mind functions below my waistline," she admitted. "My troubles are connected with sex." After some hesitation she added, "But not with ordinary sex as intercourse."

As her relationship to me intensified she said, "Don't call me by my last name. Call me by my first name. My husband has nothing to do with my future. They eliminated him and my son from my life forever." She began a campaign against my wife and tried to convince me that I should "let her go away." Jesus, the patient said, demanded of his disciples to forsake their parents and relatives. "If you want to finish your psychiatric training you can't live with your wife." "Besides," she added, "your marriage is illegal because you were not a citizen."

After three months of daily sessions our meetings were cut to twice a week because of an increase in my case load. The change was very soon reflected in the behavior of the patient. The influential figures "forbade" her to do anything but read. Her attitude toward me also changed. "What is it you want from me? I cannot please you as you want me to. Happiness is above the waistline." After what seemed to be deliberation, she added, "We cannot commit adultery right here. We have to wait until we go to California. There adultery is permitted."

Following a five day period in which I was not able to see her, the patient showed her resentment by saying, "The best we can do is that you go your own way and I shall go my own way. The attendants want to eliminate you from the scene. They try to keep the two of us apart. They demand that I don't see you."

On this day the patient also asked, "Why is it that one day you have an accent and another day you don't have one?" "How is it today?" I asked. "Today you have an accent," she answered.* I understood that she felt neglected.

She began to show moodiness on the ward and was easily provoked into verbal strife. However, she made attempts to control her emotions and on several occasions she regretfully admitted to me, "Today I blew my top

* Frieda Fromm-Reichmann has reported a similar observation in *Principles of Intensive Psychotherapy*, University of Chicago Press, 1950.

again. I should not have done it. They want me to keep my mouth shut when I am annoyed."

Gradually the patient adjusted herself to the new situation and no longer reproached me for "neglecting" her. She became friendly again and volunteered a compromise: she would not go to the occupational therapy shop, but would work in her room if the material was brought to her. She also asked for permission to visit her sister, which was a most striking development in a person who would not leave her room for many years.

I invited the sister to come and suggested the possibility of her taking the patient home for a visit. The sister arrived, gave the patient one of her own suits to wear (the patient's clothes were shabby), and took her out for a ride and a shopping tour. The patient was friendly and cooperative but mentioned some of her delusions in the course of their conversation. These frightened the sister so much that she hastily brought the patient back and left the hospital, first telling the patient that she would take her home for a visit if the doctor permitted it. She had no intention of doing so, but the patient was left with the impression that I had forbidden the hoped-for visit. When I next went to see her, she flew at me and slapped my face, breaking my glasses.

The next day she was contrite. She gave me a red pencil and told me I looked better and would see better without my glasses. She continued to refer to this episode in the following days in a very friendly manner, as if she believed she had actually done me a kindness.

About this time I began to devote an hour a day to a negro woman on the same ward. The patient became quite threatening to me and interrupted my session with the other patient, demanding to see me immediately. I told her kindly but firmly that I would talk with her the next day when she was not so excited. She did not mention the other patient next day and never referred to it again.

Within a month I was transferred to another ward. I prepared her for this change gradually and introduced her to my successor who is continuing her treatment. I promised to come back and visit her whenever I could. She seemed to accept this. Although she still maintains her seclusiveness, she remains accessible to suggestions and responsive to attention.

At a recent conference of the staff, it was decided that the patient now shows a degree of integration and a limited kind of adjustment which precludes lobotomy. It is my impression that this patient is one who could make considerable more improvement, if she could receive intensive psychotherapeutic treatment over a long period. This kind of work is impossible under our present conditions of an insufficient staff, and a large number of patients.

It is not my purpose to indicate that this patient received great benefit from our association of nine months, although she is evidently more comfortable and less of a problem.

Conclusion

The only reasons for reporting this patient's case are: (1) the remarkable fact that in spite of long hospitalization and an almost complete withdrawal from other human beings, she was still responsive and able to develop a quite intense relationship to a therapist; (2) that this relationship was strong enough to be utilized by the therapist to draw her out of part of her preoccupation, to influence her behavior, and to get her to participate in some exercise and occupational therapy; (3) that the relationship was also sufficiently durable to persist in spite of stresses (diminution of visits, rivalry of other patients, and finally a change in therapists); and (4) that her delusions, including some quite striking oral impregnation fantasies, were quite intelligible and meaningful in their own special way.

BOOK NOTICES

Research in Medical Science. DAVID E. GREEN AND W. EUGENE KNOX, eds. Price $6.50. Pp. 492. New York, Macmillan, 1950.

A collection of 26 essays by prominent investigators reviewing recent progress and current opportunities in as many phases of medical research. The entire field of medicine is covered, but particular emphasis is placed on biochemical studies fundamental to clinical practice. This may reflect the orientation of the editors but is equally indicative of the importance of this approach in current medical research. Dr. Karl Menninger contributes the chapter on research in psychiatry. Any physician may read this book with pride in past accomplishments and a stimulating sense of the immediacy of future developments. (Samuel Zelman, M.D.)

The Body. By WILLIAM SANSOM. Price $2.75. Pp. 215. New York, Harcourt Brace, 1949.

This is a fictionalized account, cast in autobiographical form, of the development of systematized delusions of infidelity—and "acute paranoid state." The history of this development is vividly and faithfully recorded. The sudden disappearance of the affliction at the end of the book is, unfortunately, less familiar and less convincing. (K. A. M.)

Expert Committee on Mental Health. World Health Organization Technical Report Series, No. 9. Price $.30. Pp. 41. New York, Columbia University Press, 1950.

This pamphlet summarizes the deliberations of the five man Expert Committee on Mental Health which acted in an advisory capacity to the World Health Organization in Geneva in 1949. It concludes with seven pages of condensed recommendations, emphasizing particularly the necessity for the utilization of mental health principles in all aspects of public health. The next meeting of the Committee will be devoted to detailed consideration of the implementation of this concept. (W. C. M.)

Be Your Real Self. By DAVID HAROLD FINK. Price $2.95. Pp. 307. New York, Simon & Schuster, 1950.

By means of rules and formulae, the author outlines a "three-pronged attack on unhappiness," incorporating principles of relaxation therapy (taken from his earlier book *Release from Mental Tension*), adjustment therapy (which the author bases on Adler's teachings), and attitude therapy (based on Korzybski's principles of general semantics). This formulation of a direct intellectual approach may be helpful to those with peripheral problems of adjustment. But there is no appreciation of the irrational or unconscious factors underlying patterns of maladjustment, or of psychodynamic theories which have been applied to their understanding. (Alice Folsom)

The Yearbook of Psychoanalysis, Vol. 5, 1949. SANDOR LORAND, ed. Price $7.50. Pp. 317. New York, International Universities Press, 1950.

It is perhaps symbolic and a feature of considerable honesty that the book opens with the seriously critical, "Symposium on the Evaluation of Therapeutic Results," by Oberndorf, Greenacre, and Kubie. All the

rest of the book shows that in spite of laborious and in many respects rather promising efforts, the science of psychoanalysis is as far from reaching a definite level of "maturity" as ever. The solid, instructive and convincing fruits of the daily clinical work (as for instance in Berta Bornstein's conscientious paper about "Emotional Barriers" and Feldman's "Mannerisms of Speech") and the most splendid theoretical argumentation (as in Franz Alexander's "Critical Discussion") show always more the, so to speak, "tactical" exploits of excellently gifted individuals of our guild than a steady "strategical" advance of the main body of our science toward something which could be called standards of method. (Hellmuth Kaiser, Ph.D.)

Measuring Results in Social Casework. By J. McV. Hunt, and Leonard S. Kogan. Price $1.50. Pp. 79. New York, Family Service Assn. of America, 1950.

Testing Results in Social Casework. By J. McV. Hunt, Margaret Blenkner and Leonard S. Kogan. Price $2. Pp. 64. New York, Family Service Assn. of America, 1950.

These two complementary booklets report one of the first serious attempts to evaluate the results of social casework in terms of the variable known within the profession as *movement.* It seems that a group of social workers who are exposed to an intensive training in reporting their work and in evaluating certain critical changes in their clientele (subsumed under the variable *movement*) can agree on the degree of change occurring between the "opening" and "closing" of a case. The hope is that the methodology of the study is applicable over the greater part of the field of social casework (and perhaps in other treatment situations) so that a comprehensive survey of the usefulness of casework may be undertaken on a wide scale. (Donald Watterson, M.D.)

Practical Neurological Diagnosis, ed. 4. By R. Glen Spurling. Price $5. Pp. 268. Springfield, Charles C. Thomas, 1950.

This revised and enlarged edition of what was originally a valuable book for students and medical practitioners remains the best thing of its kind available in this country. The reviewer is familiar with all previous editions and awaits a fifth edition as progress is made in neurology, neurosurgery, and neurophysiology. (James B. Campbell, M.D.)

Dynamics of Prejudice. A Psychological and Sociological Study of Veterans. By Bruno Bettelheim and Morris Janowitz. Price $3.50. Pp. 227. New York, Harper & Bros., 1950.

This, in the reviewer's opinion, is the best of the five volumes in this series of Studies in Prejudice because more than in any of the others it gets away from the implication that the Jews are the chief objects of human prejudice. More definitely than in any of the others the psychology of the object of preference is to some extent examined. (K. A. M.)

A Comparison of Diagnostic and Functional Casework Concepts. Cora Kasius, ed. Price $2. Pp. 169. New York, Family Service Assn. of America, 1950.

The discussion of the basic concepts of the two orientations of casework

leads the reader to expect startling differences in their practice. The "diagnostic" school is based on Freudian theories of personality whereas the "functional" school is built on the theory of will psychology of Otto Rank. The discussion builds up a good deal of curiosity about the examples of actual practice, but the conclusion from the case presentations—the main body of this committee report—is that the differences lie in trivia. The similarities in the four treatment processes are striking. Whether this fact is a reflection of an unfortunate choice of case illustrations or new evidence of the academic nature of the whole controversy is still the question. (Helvi Boothe)

The Future in Medicine. The March of Medicine, 1949. Price $2.50. Pp. 160. New York, Columbia University Press, 1950.

This latest volume of the New York Academy of Medicine's annual lectures to the laity contains five informative essays. Shorr's talk on endocrine function in bodily economy, and Boyd's lecture on newer anthropologic knowledge gained from studies of blood groups in widely-separated peoples are stimulating and novel; (Boyd provocatively suggests that the antigen-antibody reaction is an early mode of separating self from not-self). Of particular psychiatric interest are the articles by Gardner on "The Criminal Within Us" and the now classic and horrifying "Science Under Dictatorship" by Leo Alexander. This last alone is worth reading for the mountain of damning and damnable facts about Nazi corrupt medical science, genocide, and ktenology (the science of killing). (Gerald Aronson, M.D.)

Anti-Semitism and Emotional Disorder: A Psychoanalytic Interpretation. By NATHAN W. ACKERMAN AND MARIE JAHODA. Price $2.50. Pp. 135. New York, Harper, 1950.

This is one of five volumes in a broad research study on prejudice sponsored by the American Jewish Committee. This particular volume examines the data reported by a number of cooperating psychoanalysts with reference to the anti-Jewish attitudes of some of their patients. No comparable studies of anti-Gentilism or other fixed, negative attitudes are included. The introduction by Carl Binger indicates that the authors assume anti-Semitism to be a disease, "an obscenity and a sin against the human spirit." The data indicate that expressed anti-Semitism of the patients quoted usually had special conditioning, plus irrational justification for continuance. (K. A. M.)

Current Therapy 1950. HOWARD F. CONN, ed. Price $10. Pp. 736. Philadelphia, W. B. Saunders, 1950.

There is no competitor to this readily accessible and up-to-date reference to authorities. Most articles are brief, but they describe treatment in exacting detail. Every physician who treats patients can use this book. (Robert J. Kinney, M.D.)

Psychoanalysis: Evolution and Development. By CLARA THOMPSON. Price $3. Pp. 252. New York, Hermitage House, 1950.

Dr. Thompson effectively demolishes psychoanalysis as she understands it. In its place she offers the new "culturalist" orientation toward human

development with its more profound interpretation of behavior as outgrowths of the "interplay of personalities" and the "dynamic interaction between people." For the remarkable simplifications and simple prejudices (amply apologized for, therefore undone) of this book, there is no debt of gratitude owed the author by Sullivan, Horney, or Fromm. Psychoanalysis should be able to survive this critique. (Milton Wexler, Ph.D.)

The Question of Lay Analysis. By SIGMUND FREUD. Price $2.50. Pp. 125. New York, W. W. Norton, 1950.

A new translation by Nancy Proctor-Gregg of one of Freud's significant works which has been out of print and unavailable for many years. This worthwhile addition to the English translations of the writings of Freud contains a detailed discussion of the problem of medical versus lay analysts into which is also incorporated one of his simplest and most lucid explanations of psychoanalysis. (Murray Bowen, M.D.)

Introduction to Psychosomatic Medicine. By C. ALBERTO SEGUIN. Price $5. Pp. 320. New York, International Universities Press, 1950.

Its limited distribution in the United States makes the appearance of this translation from a Spanish text a fortunate event for the American reader. In general the volume is a thorough and penetrating presentation of the holistic concept. This is to be understood, in the author's words, as "a psychosomatic tendency in medicine, which has as its aim the study of men as a whole, a totality, considered as such in health and in disease, and the application of the conclusions of such study to diagnosis, prognosis, and treatment."

The introduction by Flanders Dunbar is noteworthy. Minor faults of this volume (which might easily be modified in subsequent editions) are the inconvenient arrangement of the bibliography and the absence of an index. These criticisms, however, should not be construed as negating the basic worth-whileness of this much needed volume. (Sidney Rubin, M.D.)

Patterns of Panic. By JOOST A. M. MEERLOO. Price $2. Pp. 120. New York, International Universities Press, 1950.

The author attempts to discuss what panic is, what influences panic reactions among people then proceeds to discuss our panicky world and offers a few suggestions as to how to overcome panic. The book as a whole is descriptive and does not offer the reader a very solid basis for understanding either the genesis of panic reactions or the basis of dealing with them in advance of their occurrence. My reaction to the book is that it is relatively superficial in offering to the serious reader much more than a bit of evidence on a topic which needs a great deal more analysis and discussion. (Robert G. Foster, Ph.D.)

Personality. By CHARLES M. HARSH AND H. G. SCHRICKEL. Price $5. Pp. 518. New York, The Ronald Press Company, 1950.

The authors state that their aim is to introduce "the reader to the field in a way that will minimize theoretical biases" and secondly to "aid development of an inclusive perspective toward personality study." The achievement of these aims for a topic which practically encompasses the entire field of psychology is a most difficult task. By and large the book is a very readable survey, with little attempt at synthesis. It is addressed

mainly to beginning students and is divided into two major sections, entitled "Nature and Development of Personality" and "Personality Study in Theory and Practice." (Bernard Steinzor, Ph.D.)

Sexual Deviation. By LOUIS S. LONDON AND FRANK S. CAPRIO. Price $10. Pp. 702. Washington, D. C., Linacre Press, 1950.

The authors present a well-written, psychodynamic and comprehensive approach to the problem of sexual deviations. In addition to the rich and abundant clinical material, the book includes a historical survey, sociological considerations and treatment aspects of the sexual perversions which are rewarding to the reader. It is emphasized that sexual deviations are more widespread than is commonly accepted and can be termed perversions only when they dominate the picture. The authors report uniformly good therapeutic results in their case records and consequently feel that "psychoanalysis today offers the sexual deviate the greatest hope for a lasting cure." (Harold L. Meyers, M.D.)

The Envelope. By JAMES F. PLANT. Price $3. Pp. 299. New York, Commonwealth Fund, 1950.

For many years Dr. Plant was a familiar figure at psychiatric meetings, stimulating discussion of children's problems by his pertinent questions. He died in 1947, leaving the manuscript of this book incomplete. It represents well his "strong clinical feeling for the child . . . his warmth and restless curiosity." It is alogical and unsystematic but full of provocative questions and propositions. (K. A. M.)

The Liberal Imagination. By LIONEL TRILLING. Price $3.50. Pp. 303. New York, Viking Press, 1950.

A ranking literary critic writes authoritatively and delightfully in this collection of essays about writers and writing, art and psychology, politics and culture. Trilling discusses Freud and Literature alongside Huckleberry Finn and Sherwood Anderson. A combination of good writing and good criticism makes this book a pleasure to read. (Mary Douglas Lee)

Thomas W. Salmon, Psychiatrist. By EARL D. BOND. Price $3. Pp. 237. New York, W. W. Norton, 1950.

A delightfully written, interesting biography of one of the founders of the National Committee for Mental Hygiene, the chief of army psychiatry for the AEF and the Professor of Psychiatry for Columbia University, containing a description of his work, his family and even his eccentricities. It is a story of a great psychiatrist written by another great psychiatrist. (W. C. M.)

Child Treatment and the Therapy of Play, ed. 2. By LYDIA JACKSON AND KATHLEEN M. TODD. Price $2.50. Pp. 159. New York, Ronald Press, 1950.

Parents, teachers, and physicians are given a simple and yet thoroughly sound picture of the goals and methods of child therapy. Appropriately interwoven is a description of the child's emotional development and of Guidance Clinic practices. The last two chapters deal specifically with play therapy and seem to be addressed more directly to the beginning therapist while still remaining understandable to the informed layman.

This readable little book accomplishes a difficult task in splendid fashion. (Edwin S. Kessler, M.D.)

Proceedings of the First Clinical ACTH Conference. JOHN R. MOTE, ed. Price $5.50. Pp. 607. Philadelphia, Blakiston, 1950.

This book demonstrates a new high in commercial research of interest to psychiatrists. It demonstrates that in schizophrenia and involutional psychosis, there is a lack of endocrine responses to stress, and to ACTH. Shock therapy studies do not suggest involvement of the pituitary-adrenal mechanism. ACTH in no way helped toxic psychosis or severe anxiety—multiple sclerosis is not helped. Acute alcoholism and D.T.'s at last have a specific cure in ACTH! (R. J. Kinney, M.D.)

Handwriting Analysis. By ULRICH SONNEMANN. Price $5. Pp. 276. New York, Grune & Stratton, 1950.

This book is more than the first serious introduction to modern graphology in this country. By freeing his principles of investigation from their vitalistic philosophy and by giving new psychological rationales for most of the basic graphological interpretations, the author shows—theoretically and in many practical examples—how to apply them to the existing standard groups of classification of the mentally ill. Not a reference book easily to be used as an encyclopedia of pathognomic signs in handwriting, but certainly useful for graphological training, not only on account of its richness of phenomenological descriptions and experience in abnormal psychology but also because of its theoretical clearness and soberness. (H. M. Graumann, M.D.)

The Art of Real Happiness. By NORMAN VINCENT PEALE AND SMILEY BLANTON. Price $2.75. Pp. 247. New York, Prentice-Hall, 1950.

The cooperation of psychiatrists with clergymen such as we use routinely at Winter VA Hospital was first attempted in the present era at Worchester, Massachusetts. This book is an account of such work as exemplified in the Marble Collegiate Church in New York. There are brief accounts of the way psychiatrists and ministers have worked with various troubled people, each with his own emphasis. In chemical terms, the book is a mixture rather than a compound, but the net effect is to demonstrate this thesis: If you can love and believe in something, you can live happily. With this general formula, without particularizations, psychiatry and religion are in full agreement. (K. A. M.)

Movies. By MARTHA WOLFENSTEIN AND NATHAN LEITES. Price $4. Pp. 316. Glencoe, Ill., The Free Press, 1950.

In a readable, stimulating, unique book, the authors have drawn generalizations based on a dynamically oriented analysis of the best American films appearing since 1945 and of contemporary British and French films. They have identified recurrent day-dreams and characteristically different handling of identical themes by the nationalities mentioned. The generalizations have considerable sociologic significance in that values, attitudes, motives, and psychologic mechanisms can be insinuated into a culture by stylized treatment of recurrent themes through identification of the audience with the characters and situations. The book is recommended for those interested in the cinema as art form and as a mass medium of communication. (Arnold M. Kallen, M.D.)